

§ 122C-115.4. Functions of local management entities.

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

- (1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.
- (2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.
- (3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.
- (4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.
- (5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:
 - a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
 - b. Addressing difficult situations for clients or providers.
 - c. Consulting with providers regarding difficult or unusual care situations.
 - d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.

- e. Coordinating client transitions from one service to another.
 - f. Conducting customer service interventions.
 - g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
 - h. Interfacing with utilization reviewers and case managers.
 - i. Providing leadership on the development and use of communication protocols.
 - j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.
- (6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.
 - (7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.
 - (7a) **(Effective October 1, 2019)** Community crisis services planning in accordance with G.S. 122C-202.2.
 - (8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:
 - a. Waiting for residential services.
 - b. Potentially eligible for CAP-MRDD.
 - c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an LME may contract with a public or private entity for the implementation of LME functions designated under subsection (b) of this section.

(d) Except as provided in G.S. 122C-124.1 and G.S. 122C-125, the Secretary may neither remove from an LME nor designate another entity as eligible to implement any function enumerated under subsection (b) of this section unless all of the following applies:

- (1) The LME fails during the previous consecutive three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).
- (2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at least three months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.
- (3) If, after three months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.

(e) Notwithstanding subsection (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Health and Human Services.

(f) The Commission shall adopt rules regarding the following matters:

- (1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.
- (2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.
- (3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section.

(g) The Commission shall adopt rules to ensure that the needs of members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members are met by requiring:

- (1) Each LME to have at least one trained care coordination person on staff to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Juvenile Justice Section of the Division of Adult Correction and Juvenile Justice, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.
- (2) LME staff members who provide screening, triage, or referral services to receive training to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and their families. The training required by this subdivision shall include training on at least all of the following:
 - a. The number of persons who serve or who have served in the active or reserve components of the Armed Forces of the United States in the LME's catchment area.
 - b. The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including traumatic brain injury, posttraumatic stress disorder, depression, substance use disorders, potential suicide risks, military sexual trauma, and domestic violence.
 - c. Appropriate resources to which these service personnel and their families may be referred as needed. (2006-142, s. 4(d); 2007-323, ss. 10.49(l), (hh); 2007-484, ss. 18, 43.7(a)-(c); 2007-504, s. 1.2; 2008-107, s. 10.15(cc); 2009-186, s. 1; 2009-189, s. 1; 2011-145, s. 19.1(h); 2011-185, s. 6; 2011-291, s. 2.45; 2012-66, s. 2; 2012-83, s. 43; 2017-186, s. 2(nnnnn); 2018-33, s. 6.)